

# TAKING SYSTEMS CHANGE TO SCALE: BUILDING REPLICABLE PROCESSES

Drs. Lyons, Walton, Israel and Friedman  
*2013 Tampa Conference*


# PURPOSE

- ▶ Identifying replicable strategies for system improvement, focusing on:
  - ▶ Creating shared understanding of system performance
  - ▶ Identifying targets for improvement
  - ▶ Achieving improvement over time

# PRESENTERS

- ▶ Robert Friedman, PhD, Discussant
- ▶ John Lyons, PhD, University of Ottawa
- ▶ Betty Walton, PhD, Indiana University
- ▶ Nathaniel Israel, PhD, SFDPH

# FORMAT / ORDER

- ▶ Introduction to TCOM (Lyons)
  - ▶ State-wide Strategies and Processes (Walton)
  - ▶ County-level: 360<sup>0</sup> Implementation (Israel)
  - ▶ Consensus Replication Strategies (All)
  - ▶ Implications for Policy and Practice (Friedman)
- 

# INTRODUCTION TO TCOM

# THREE MAJOR CHALLENGES IN THE EXISTING SYSTEM


- ▶ We are not actually managing our business.
- ▶ Serving children/youth and families is complex
- ▶ Expertise is often not resident with our direct care

# UNDERSTANDING OUR BUSINESS: THE HIERARCHY OF OFFERINGS

- I. Commodities—raw materials
- II. Products—produced for wider use
- III. Services—hiring someone to apply a product for you
- IV. Experiences—a memory
- V. Transformations—helping someone change his/her life in some fundamental way

- Gilmore & Pine, 1997

# THE PHILOSOPHY: TOTAL CLINICAL OUTCOMES MANAGEMENT (TCOM)

- ▶ *Total* means that it is embedded in all activities with families as full partners.
  - ▶ *Clinical* means the focus is on child and family health, well-being, and functioning.
  - ▶ *Outcomes* means the measures are relevant to decisions about approach or proposed impact of interventions.
  - ▶ *Management* means that this information is used in all aspects of managing the system from individual family planning to supervision to program and system operations.
- 



# THE STRATEGY: CANS

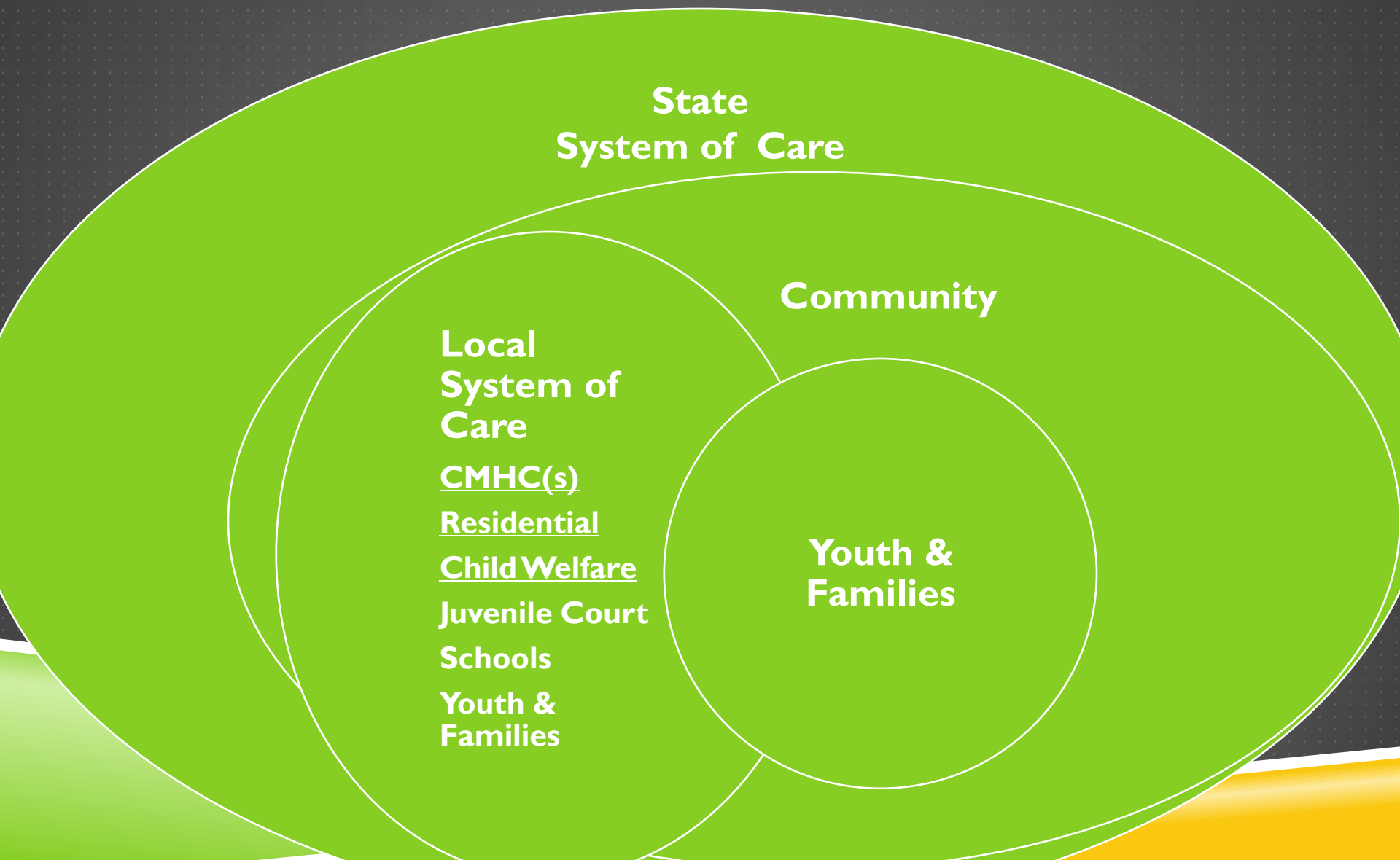
## SIX KEY CHARACTERISTICS OF A COMMUNIMETRIC TOOL

- ▶ Items are included because they might impact care planning
- ▶ Level of items translate immediately into action levels
- ▶ It is about the child not about the service
- ▶ Consider culture and development
- ▶ It is agnostic as to etiology—it is about the ‘what’ not about the ‘why’
- ▶ The 30 day window is to remind us to keep assessments relevant and ‘fresh’

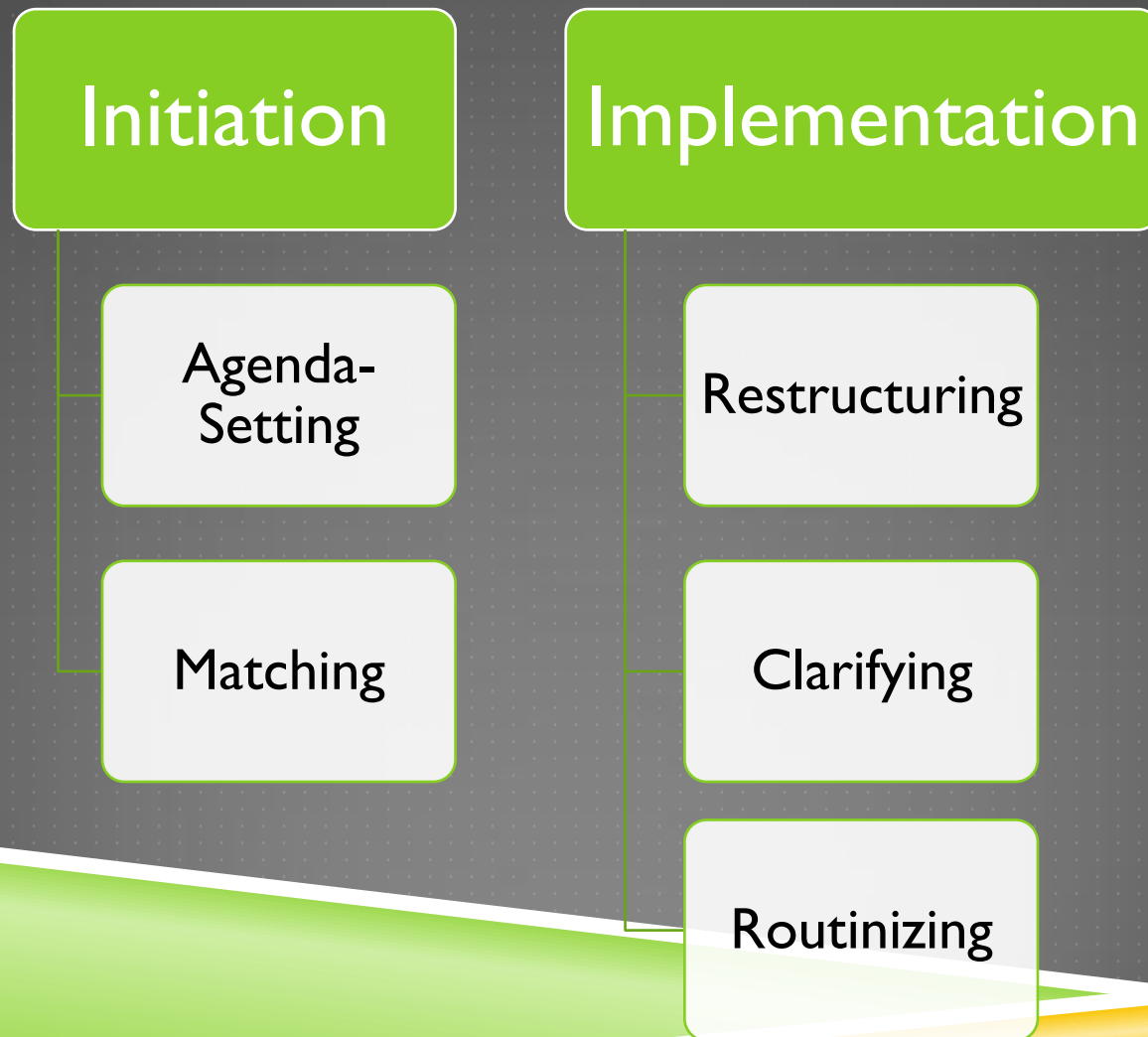
# TCOM Grid of Tactics

	<b>Family &amp; Youth</b>	<b>Program</b>	<b>System</b>
<b>Decision Support</b>	Care Planning Effective practices EBP's	Eligibility Step-down	Resource Management Right-sizing
<b>Outcome Monitoring</b>	Service Transitions & Celebrations	Evaluation	Provider Profiles Performance/ Contracting
<b>Quality Improvement</b>	Case Management Integrated Care Supervision	CQI/QA Accreditation Program Redesign	Transformation Business Model Design

# STATEWIDE IMPLEMENTATION



# DIFFUSION OF INNOVATION IN AN ORGANIZATION



# Effective Implementation Requires...



(Fixsen et al., 2005; Bruns, 2010)

# RELATIONSHIPS AMONG SYSTEMS & PROVIDERS



**CHILD  
WELFARE**



**RESIDENTIAL**



**27 CMHCS**



**DMHA**



**MEDICAID**



Purpose	DCS	Residential	CMHCs	DMHA	Medicaid
Engage	X	X	X		
Identify Needs & Strengths	X	X	X	Linked to Intensive Plans of Care	
Plan Interventions	X	X	X	Justify Intensive Plans of Care	
EBPs	trauma	X	X	Wraparound, ACT	X
Intensity of Services	Foster Care Rates Placement MRO Referrals Intensive community Services	Contract with CMHCs for Treatment Services (Medicaid)	X	Different Levels of Service based on Pattern of CANS Needs	Authorize Services: MRO Intensive Services PRTF
Monitor Progress			X	Performance Measures	X
Improve Services			X	X	X

# IMPLEMENTATION STRATEGIES & PROCESSES

- **Fidelity:** On-line training/certification
- **Retraining/Coaching:** Recruit and provide In-Person Training & Certification of Local “SuperUsers”
- **Coaching:** SuperUser Booster Workshops
- **Training:** Local/Regional for Child Welfare
- **Online/phone** consultation

## Training/Certification & TA

- **Consultation** with state & local agencies, individuals

## Technology

- **Develop Data Collection, Analysis, & Reporting**
- **Available to all systems & providers**
- **Require certification**
- **Partnership between CANSTA & IT**
- **Transition from data collection to easy access & use of information in practice, funding, policy development, & measuring outcomes**

- **State & University Partnership**
- **Incremental**
- **Add systems & agencies**
- **Ongoing activities to improve reliability and effective use of information**
- **Link funding to ratings**
- **Outcome Performance Measures**

## Implementation & Sustainability

- **Link to EBPs**
- **Integrated policies**
- **Monitor Fidelity/Progress**
- **Use information for QI**



# ACROSS LIFE SPAN

## ► CANS Birth to 5

- New Glossary includes normal development, research

## ► Adult Strengths & Needs Assessment (ANSA)

- ANSA Study (2012)

## ► CANS 5 to 17

- Enhanced item and item anchor descriptions
- Improve Trauma & Substance Use rating

## ► Comprehensive, Multi-system Tools

- CORE items expand based on complexity of needs

## 2 CANS DECISION SUPPORT MODELS

### **Behavioral Health Treatment Recommendations (5-17)**

- 0 No Services**
- 1 Outpatient**
- 2 Outpatient with Limited  
Case Management**
- 3 Supportive Services**
- 4 Intensive Wraparound**
- 5 Intensive: PRTF Waiver, MFP**
- 6 Intensive: PRTF Waiver, MFP,  
PRTF or State Hospital**

### **Child Welfare/JJ Placement\* Recommendations**

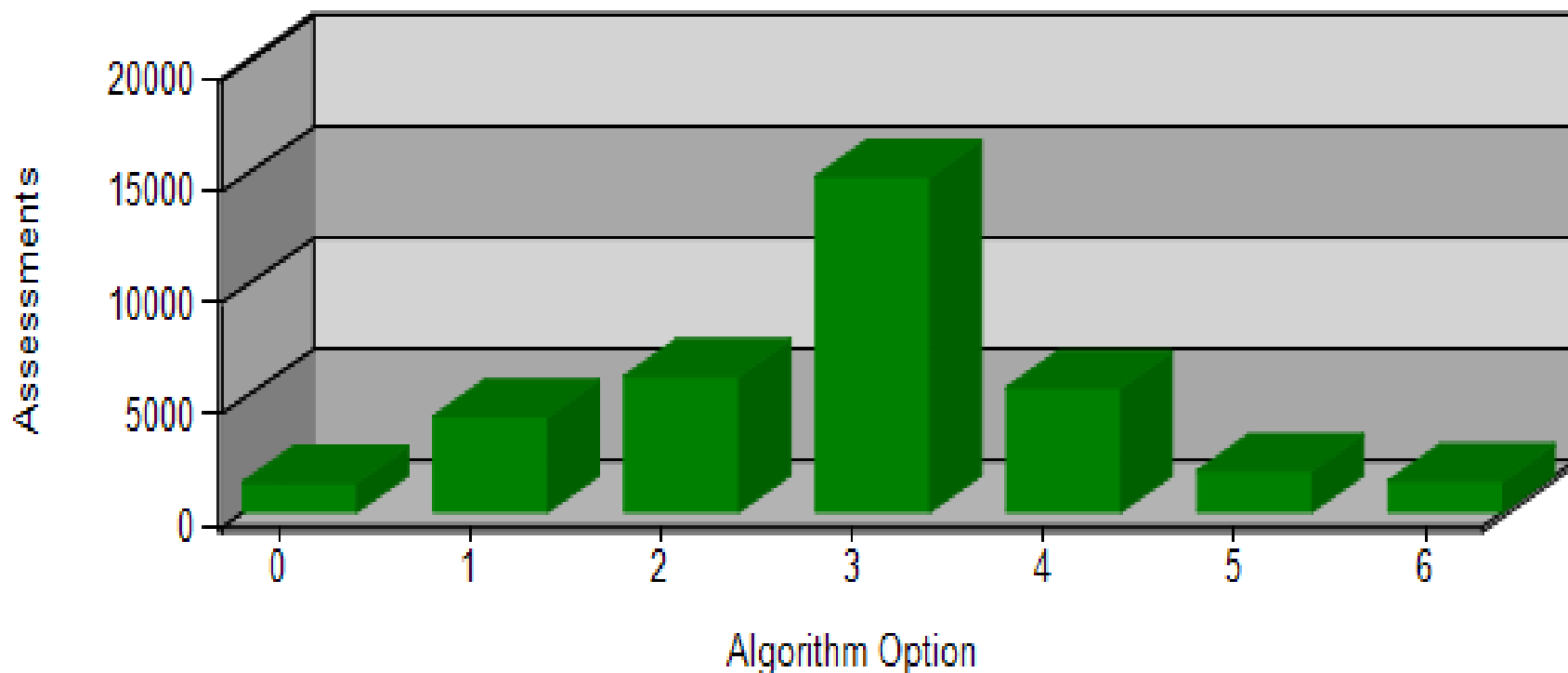
- 0 No current DCS/JJ Removal**
- 1 Foster Care**
- 2 Foster Care with Support**
- 3 Therapeutic Foster Care**
- 4 Group Home\*\***
- 5 Residential\*\***

**\*Only used when DCS or JJ have currently removed child from home.**

**\*\*Could be served in foster home, if available & safe, with treatment & Support to address identified needs.**

# BEHAVIORAL HEALTH CANS DECISION MODEL RECOMMENDATIONS

CANS Comprehensive 5 - 17 - Mental Health



**N = 35,484 Initial Assessments**  
**1/1/2012- 12/31/2012**

# PLACEMENT RECOMMENDATION

## DARMHA STATE WIDE REPORT

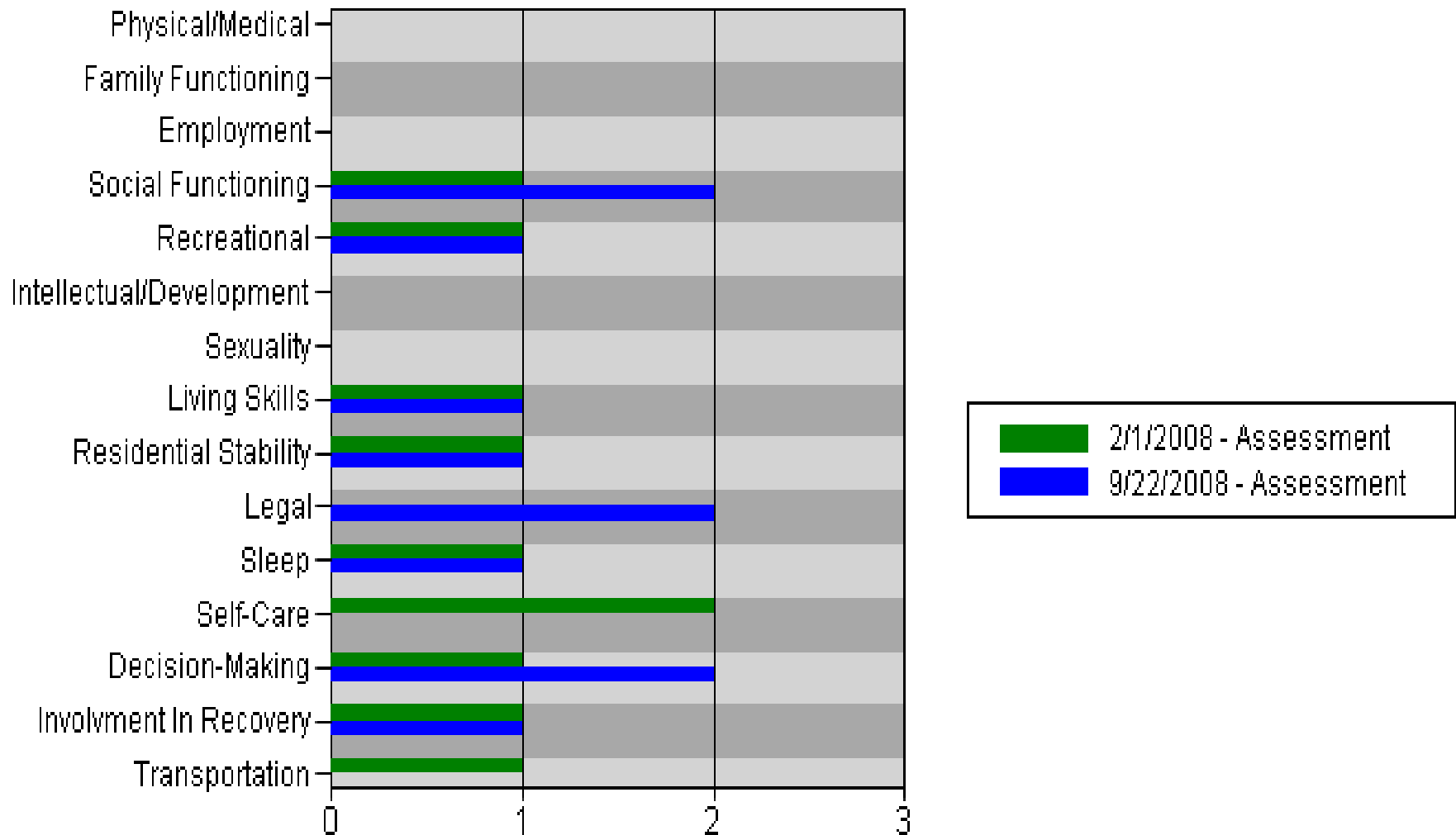
Recommended Level of Placement	# of Initial CANS
Youth at Home (Not removed by DCS/JJ)	27,446
Foster Care	1,264
Moderate Foster Care (+ Services)	2,650
Treatment Foster Care	1,171
Group Home for youth > 14	59
Group Home for children < 12	23
Group Home for youth 12 - 14	193
Residential	2,678

**N = 35,484 Initial Assessments**  
**1/1/2012- 12/31/2012**

<b>Strengths</b>	<b>Challenges/Questions</b>	<b>Solutions</b>
<b>Common Language</b>	<b>Rating needs of youth &amp; families in intensive services</b>	<b>Review rating basics, myths, challenges</b>
<b>Helps engage families &amp; youth</b>	<b>Who is the caregiver?</b>	<b>Clarify; permanency plan caregivers</b>
<b>Helps determine case plan, referrals, and placement, transitions</b>	<b>Gathering information in limited time – rate based on what you know or inquire further?</b>	<b>Use all available information: engage family &amp; youth, ask questions, records, share info..</b>
<b>Can help reach agreement among family, youth, DCS, &amp; providers</b>	<b>Differences in ratings among DCS, community &amp; residential providers</b>	<b>Discuss differences in rating specific items (evidence)</b>
<b>Helps new FCM look at issues that may have been overlooked</b>	<b>Perceived pressure to make ratings fit (desired placement or rate, service level)</b>	<b>Policy statements. Rate to describe real needs, then determine action.</b>
<b>Team tool – everyone has input</b>	<b>Misunderstandings between systems</b>	<b>Cross-System Booster Workshops &amp; Training</b>
<b>Helps transition youth to appropriate placement and services</b>	<b>Differences in “LON scores”</b>	<b>Focus on specific items, discussing reasons for differences in ratings</b>

# ITEM LEVEL OUTCOME REPORT

## Life Functioning Domain



# OUTCOME PERFORMANCE MEASURES

**DMHA implemented  
Outcome Performance  
Measures (funding):**

- ▶ **Youth with BH Needs**
- ▶ **Adults with SMI**
- ▶ **Adults with Substance  
Use Needs**

**Reliable Improvement in**

- ▶ **Any One Domain**
- ▶ **Substance Use**
- ▶ **School Functioning**
- ▶ **Employment**
- ▶ **Housing**
- ▶ **Community Integration**

# YOUTH & FAMILY OUTCOMES

- Since 2008, as measured by the **CANS**, about **56%** of youth who complete an episode of treatment in usual public care improve in one domain.
- In **SFY2013**, since **DCS** and residential providers systematically refer youth to **CMHCs** to access Medicaid services, improvement over the last six months decreased to **40%** for **CMHCs**, range **21.52% – 56.38%**.  
(target = 45% between last 2 assessments)
- Compare with **65%** improvement for youth participating in intensive services (**CA-PRTF** grant).
- When youth and families receive high fidelity wraparound, up to **78%** improve in any one domain.

(Walton & Moore, 2012)




# SF COUNTY: 360<sup>0</sup> IMPLEMENTATION

# DISCLAIMER

- ▶ Information in this presentation is not to be construed as the official position of the San Francisco Department of Public Health

# 360<sup>0</sup> IMPLEMENTATION

- ▶ Describe a series of supports developed over time to support multi-level alignment
  - ▶ Align with Youth and Caregiver goals, then Clinicians, Supervisors, program Directors, Administrators, State and Federal goals
  - ▶ Implement the tools, training and ongoing strategy and technical assistance to realize its potential
- 

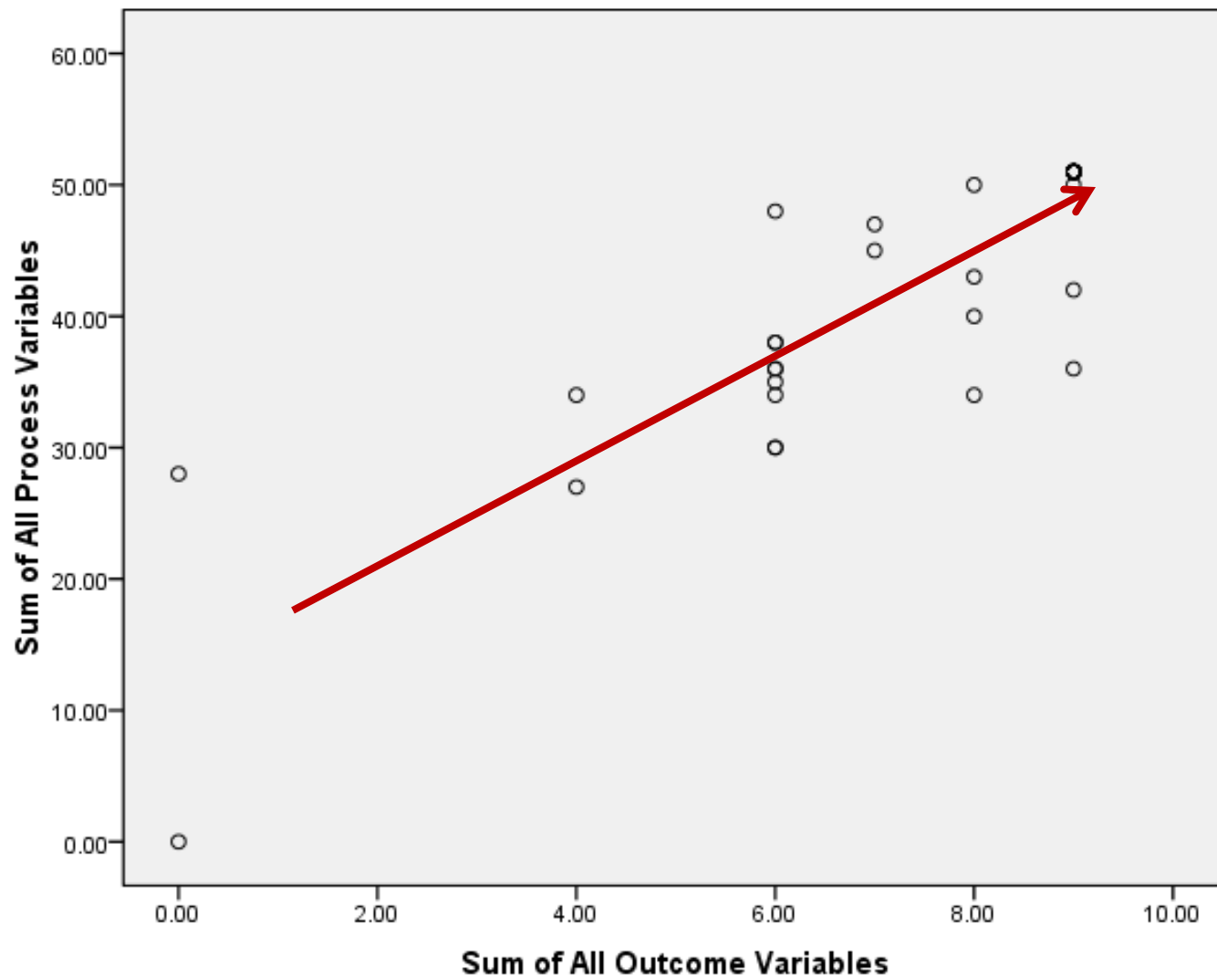
# YOUTH AND CAREGIVERS

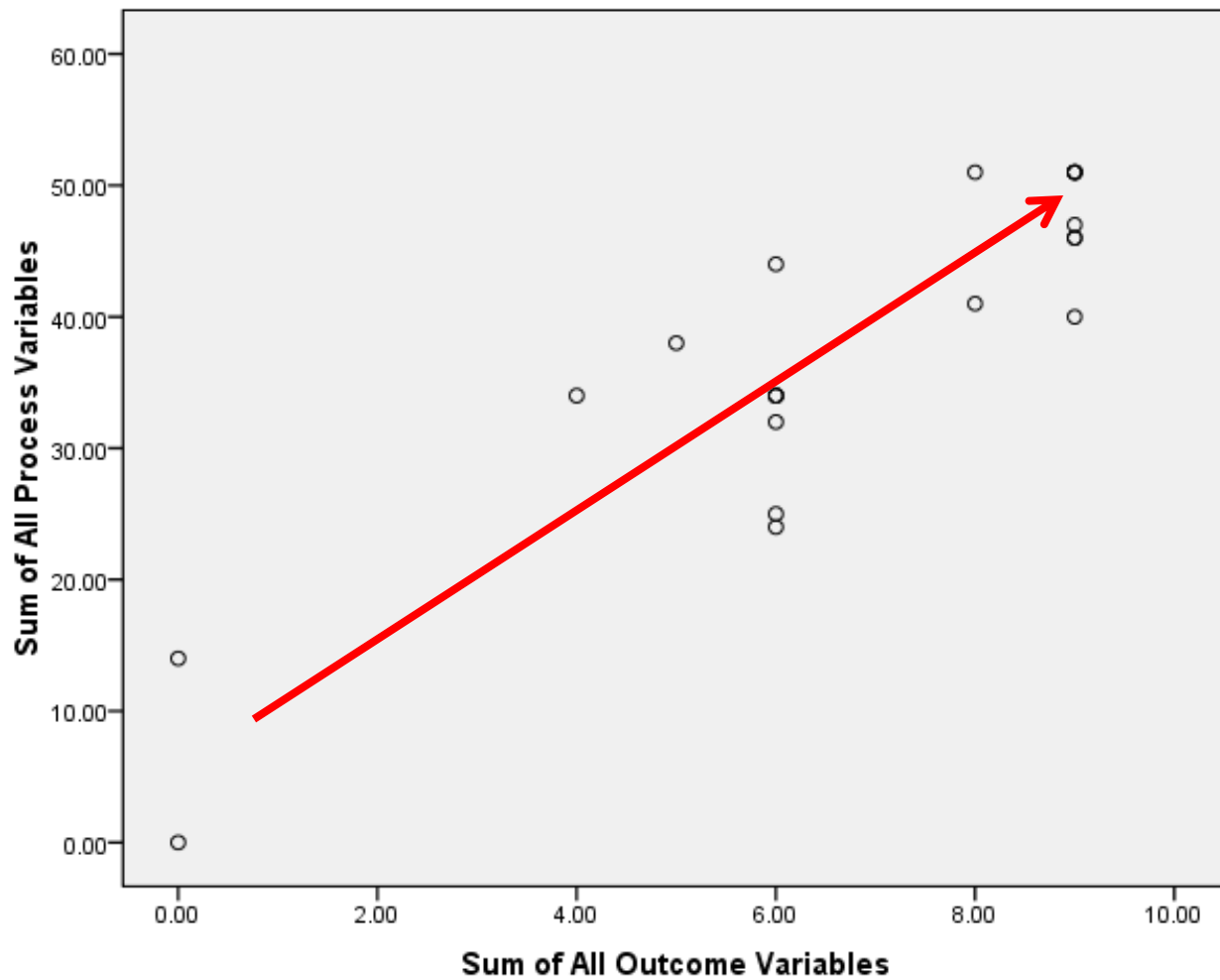
- ▶ CANS Designed as Communication and Treatment Planning tools for use with youth and caregivers
- ▶ Assessment and Treatment Planning are not often done in a collaborative, culturally-appropriate manner
- ▶ Clinicians may mis-perceive the CANS as a *barrier to engagement*
- ▶ How can this be remedied?

# YOUTH AND CAREGIVERS

- ▶ Sat down and listened to caregivers and youth: ~25 listening / working collaboration sessions
- ▶ Developed rich picture of the ways the CANS can be used as a collaboration tool across cultures, throughout the entire clinical process (from first contact to treatment transitions)
- ▶ Created interactive, multi-level curriculum co-led by a caregiver to disseminate this information and help develop collaboration skills
- ▶ Created feedback loop designed to validate engagement measure and benchmark current levels of engagement


ENGAGEMENT → OUTCOMES







# CLINICIANS

- ▶ Goal is to transform the use of the CANS from “another piece of paperwork” to value-added tool essential to meeting goals
  - ▶ Focus on key decision points in clinical work: entry, formal reviews (scheduled and episodic), transition planning
  - ▶ Provide suite of tools/views which set the stage for a collaborative Clinical Formulation
  - ▶ Align these tools/views at every level of the system, so all persons are making decisions based on the same data
- 

# CLINICIANS

## Treatment Planning Summary:



City and County of San Francisco  
Department of Public Health  
COMMUNITY BEHAVIORAL HEALTH SERVICES  
CHILD / YOUTH / CANS / MENTAL HEALTH

Today's Date: 12/10/2010

NAME: TESTCASE,DIANE

BIS#: 134

RU#: 38ARAU

### CHILD / YOUTH / CANS TREATMENT PLANNING SUMMARY

#### CANS CYF Initial Assessment

##### Presentation - Behavioral / Emotional Needs (& Trauma Symptoms)

Anxiety 2  
Oppositional 2  
Anger Control 2  
Adjustment to trauma 3

*Summary of Presentation - Behavioral/Emotional Needs: **Profound***

##### Impact on Functioning - Life Domain Functioning

Family 2  
Living Situation 2  
School Behavior 2  
School Achievement 2

*Summary of Impact on Functioning - Life Domain Functioning: **Profound***

##### Risk Behaviors

Danger to Others 2  
Judgement 2

*Summary of Risk Behaviors: **Serious***

# CLINICIANS

## Clinical Alerts:

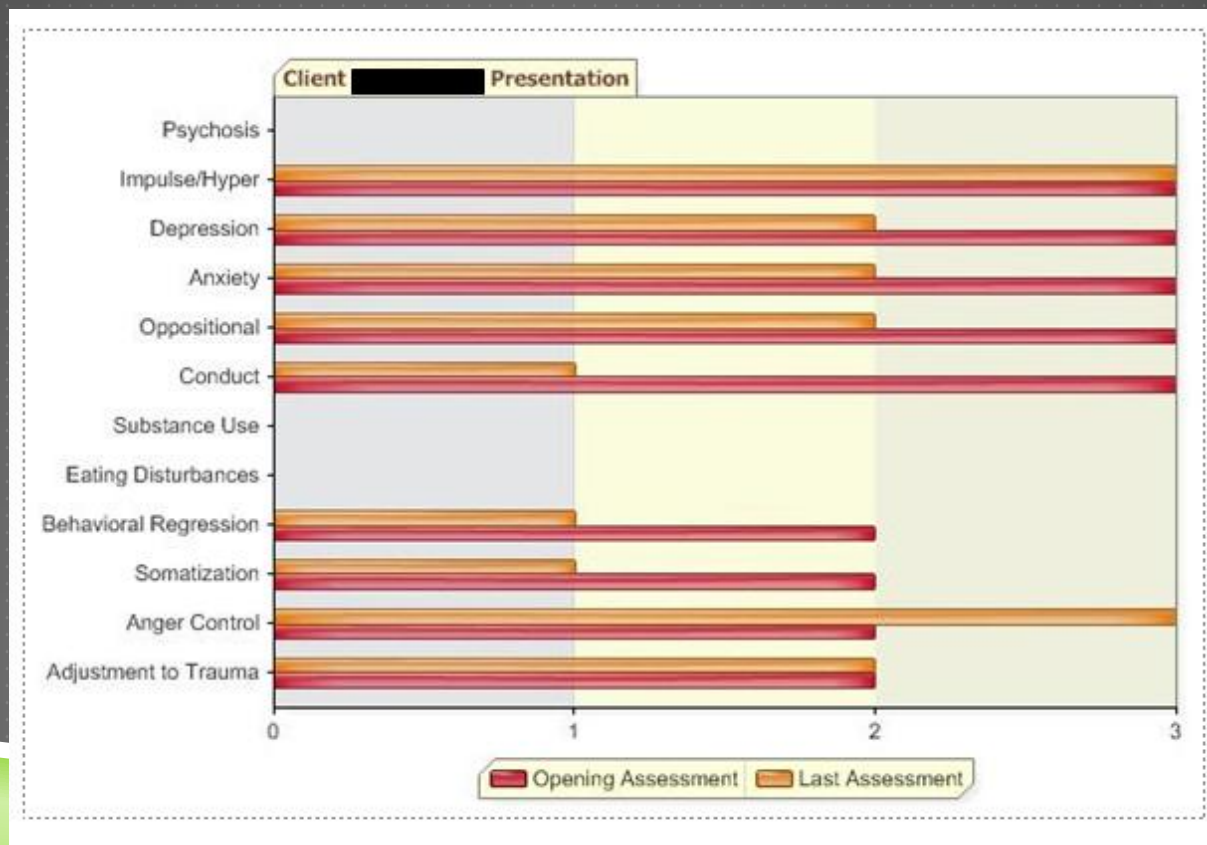
**Clinical Alert!** Your client's profile is consistent with clients experiencing high levels of anxiety, depression, and traumatic stress. Clients with a similar profile in San Francisco have been found to have:

- *Increased rates of Suicidality (nearly 15% of children / youth with this profile)*
- *Increased rates of Danger to Others (nearly 30%)*
- *Serious difficulties in School Behavior (50%), Achievement (almost 55%), and Attendance (about 35%)*
- *Increased rates of Caregiver Mental Health concerns (30%)*

**BE SURE TO THOROUGHLY ASSESS FOR THESE CONCERNS. A SUICIDE ASSESSMENT PROTOCOL IS AVAILABLE BELOW FOR CLIENTS SHOWING SIGNS OF DANGER TO SELF. THE SFDPH TARASOFF POLICY (FOR CLIENTS WHO MAY BE A DANGER TO OTHERS) IS ALSO AVAILABLE BELOW. RESOURCES FOR TREATING TRAUMA AND DEPRESSION FOLLOW THE SUICIDE ASSESSMENT AND DUTY TO WARN PROTOCOLS.**

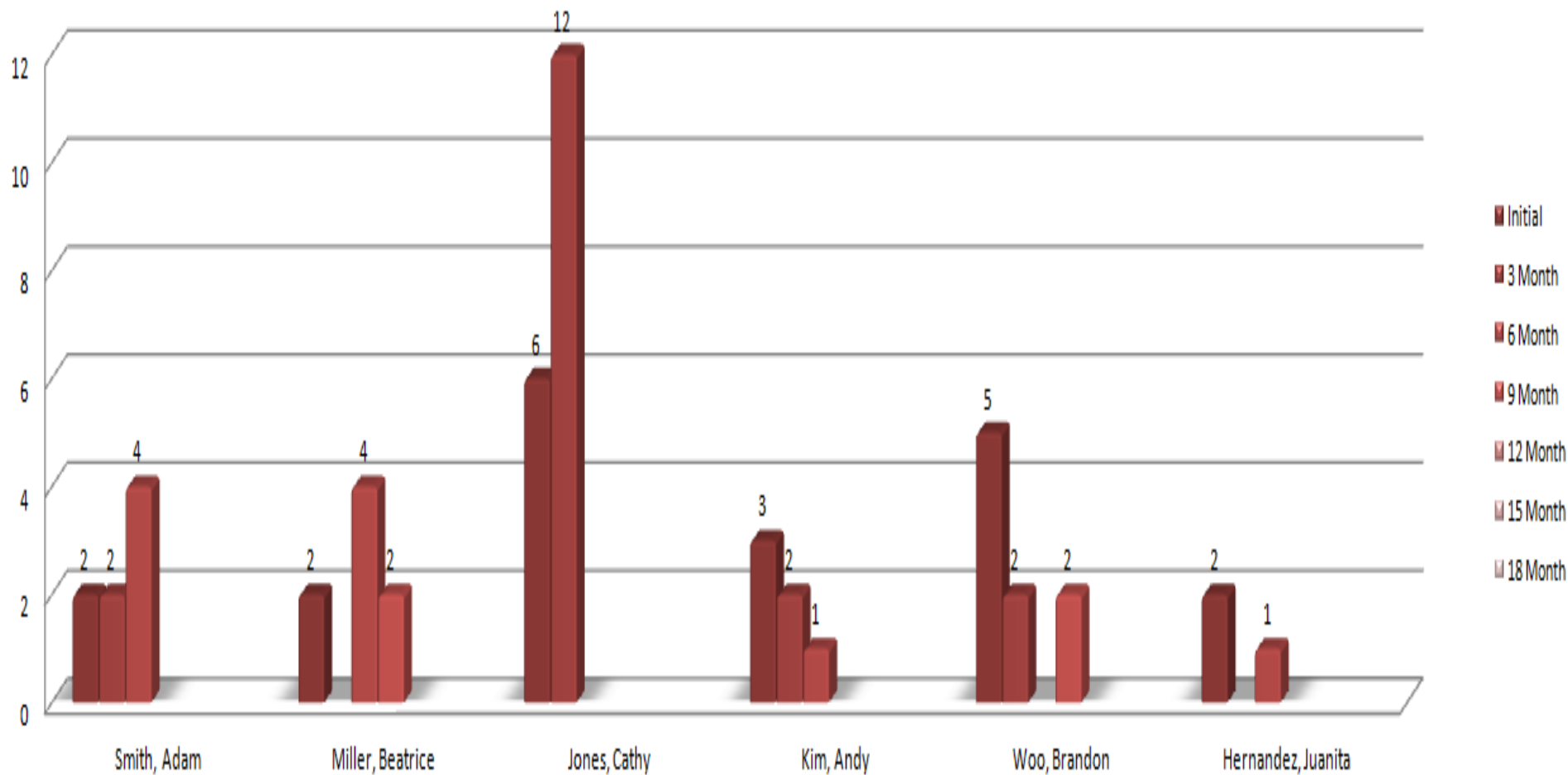
# CLINICIANS

## Client-Level Change:



# SUPERVISORS

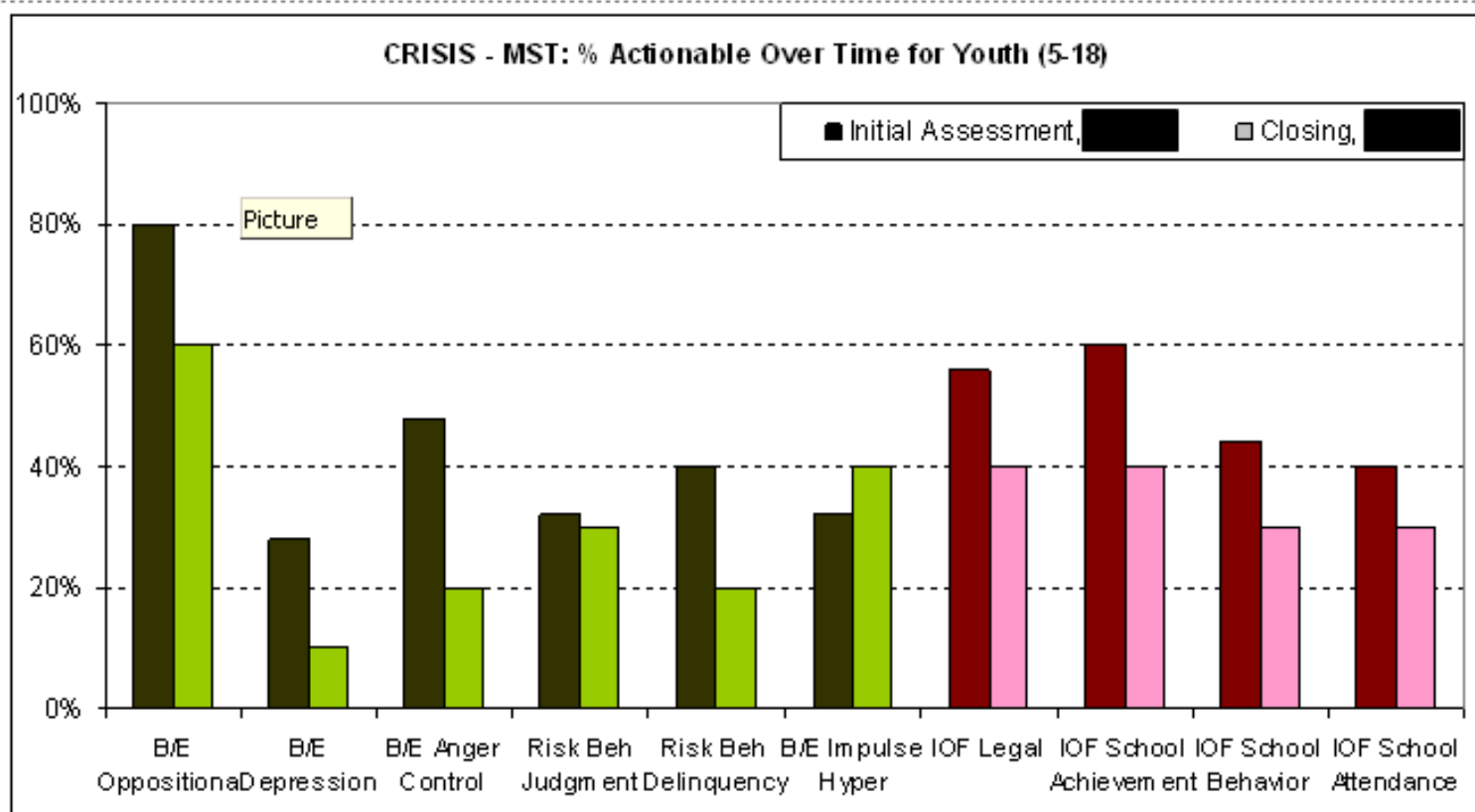
## Therapist A



# PROGRAM DIRECTORS

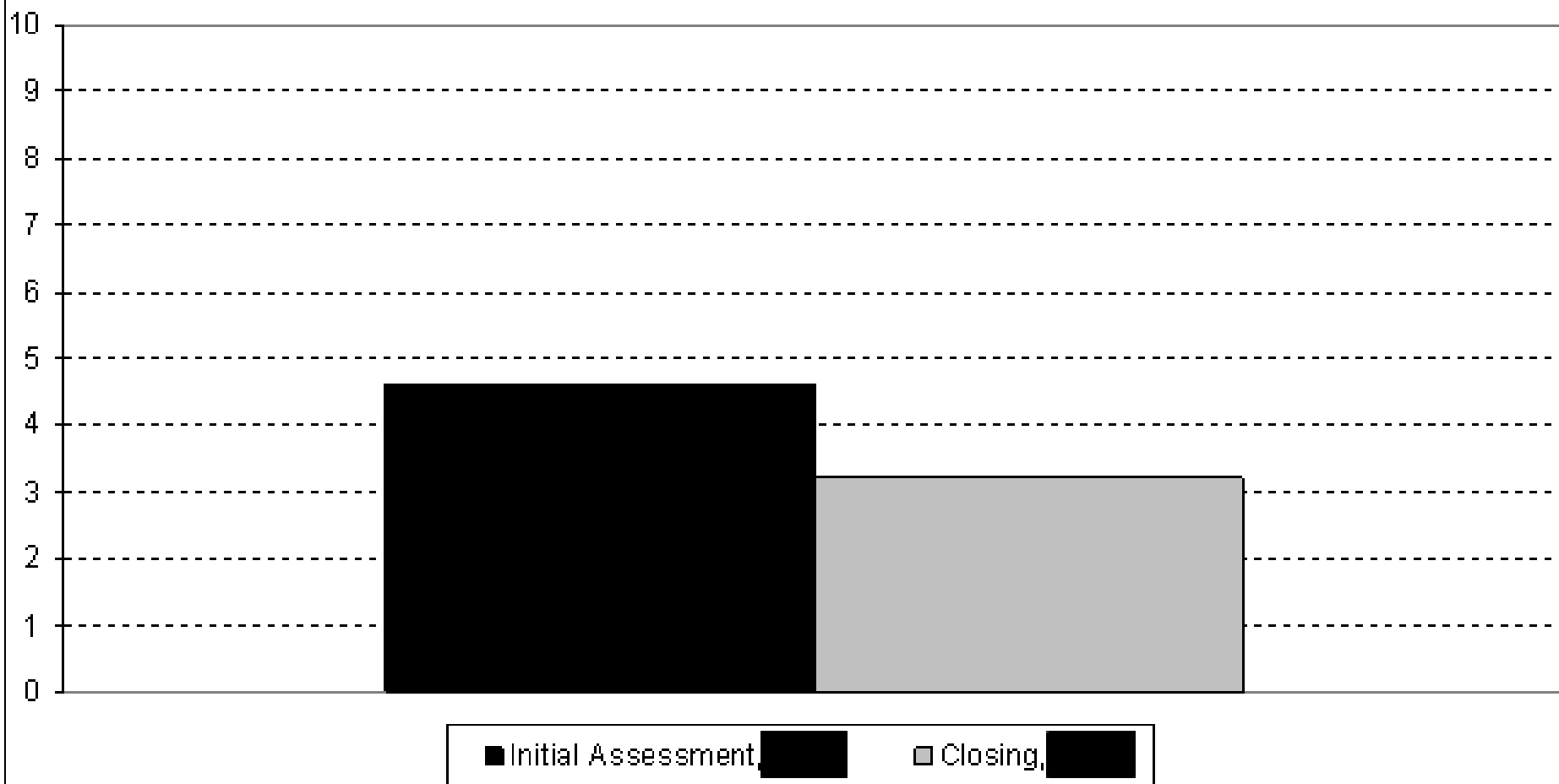
- ▶ Monthly SuperUser Calls
- ▶ Integration of CANS Objectives with Contract Objectives
- ▶ Semi-Annual Progress Reports (Moving to Quarterly, and full automation)

# PROGRAM DIRECTORS



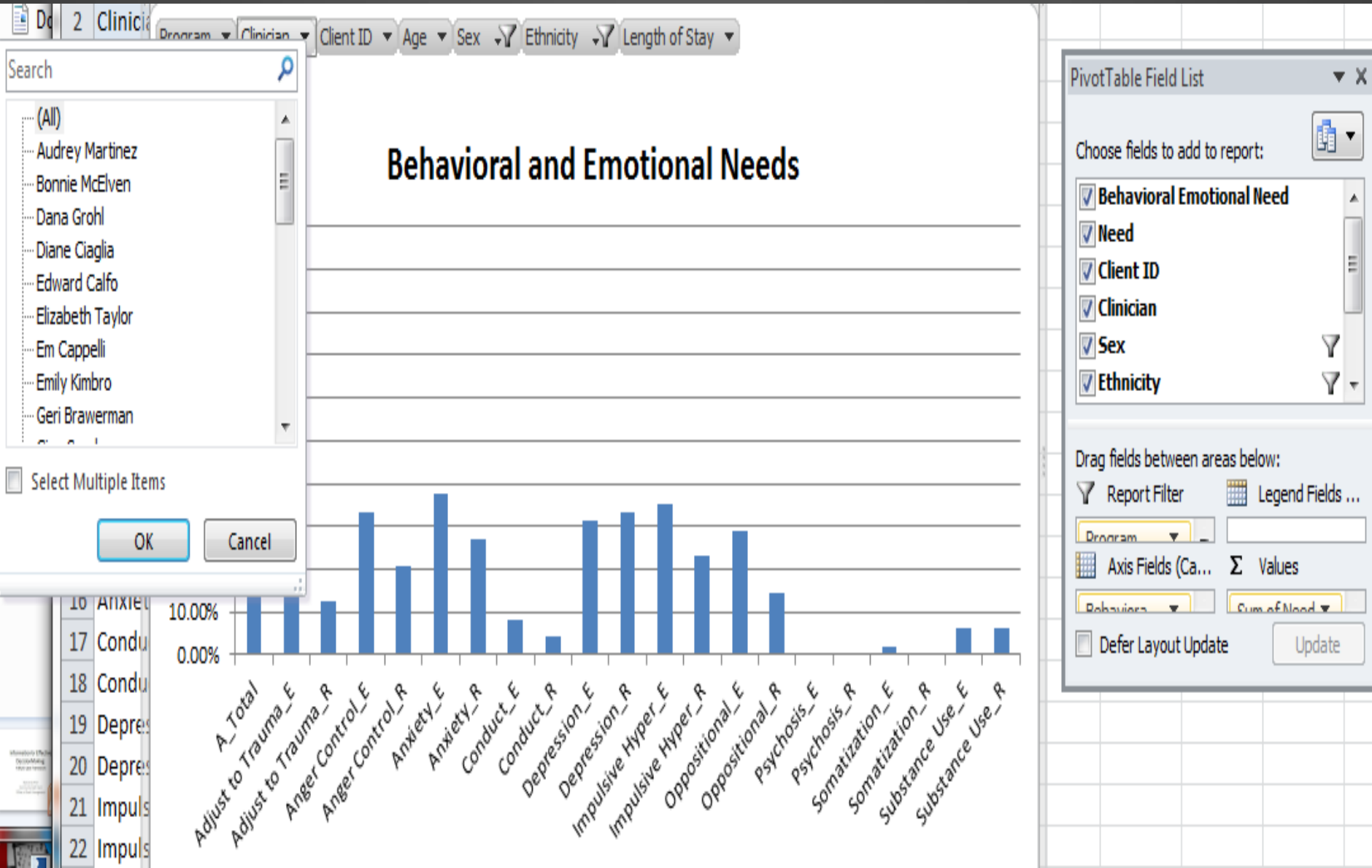
# PROGRAM DIRECTORS

**CRISIS - MST:**  
**Overall Number of Actionable TOC Items Averaged Over Youth Clients (Ages 5-18)**






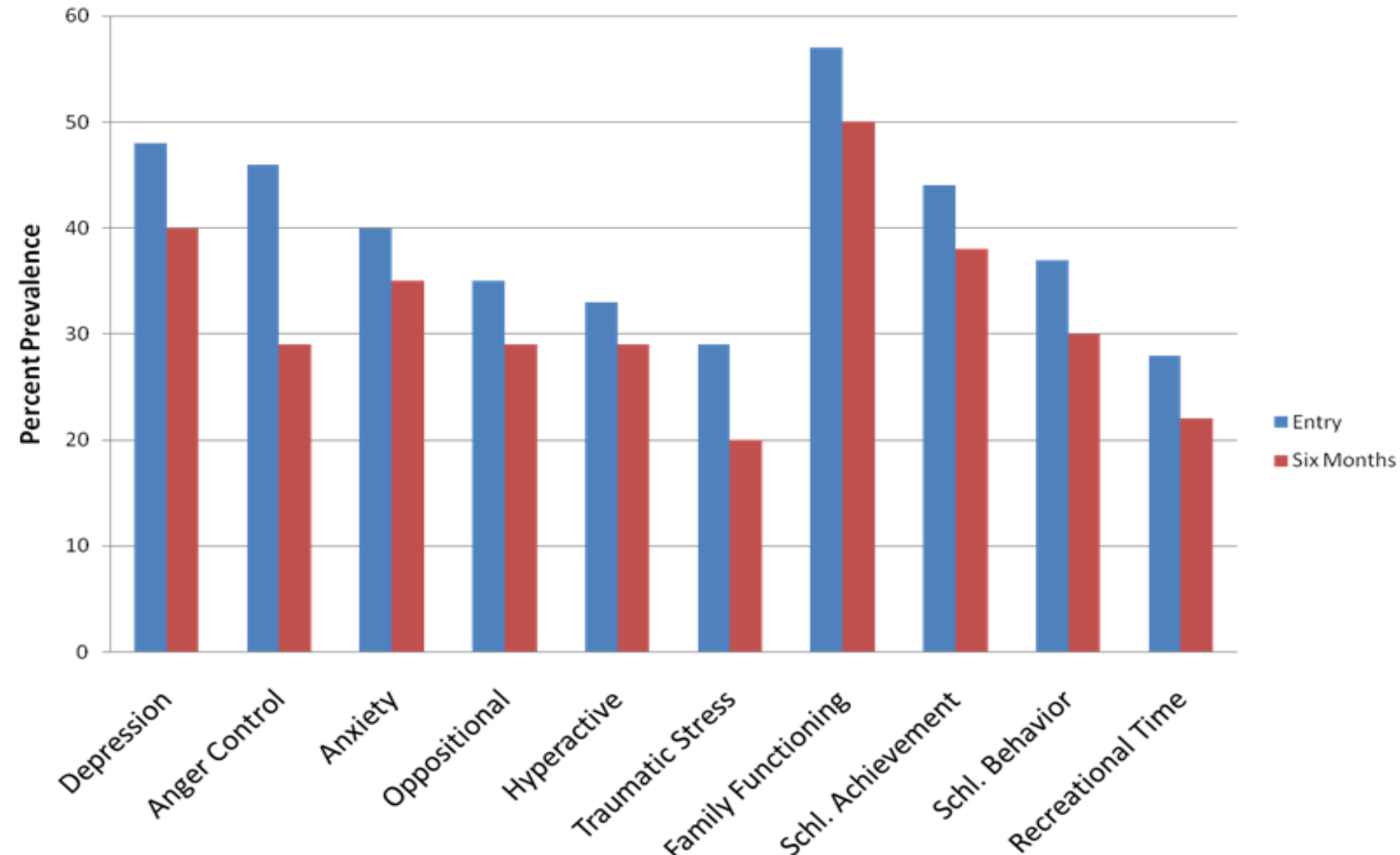
# PROGRAM DIRECTORS



# ADMINISTRATORS

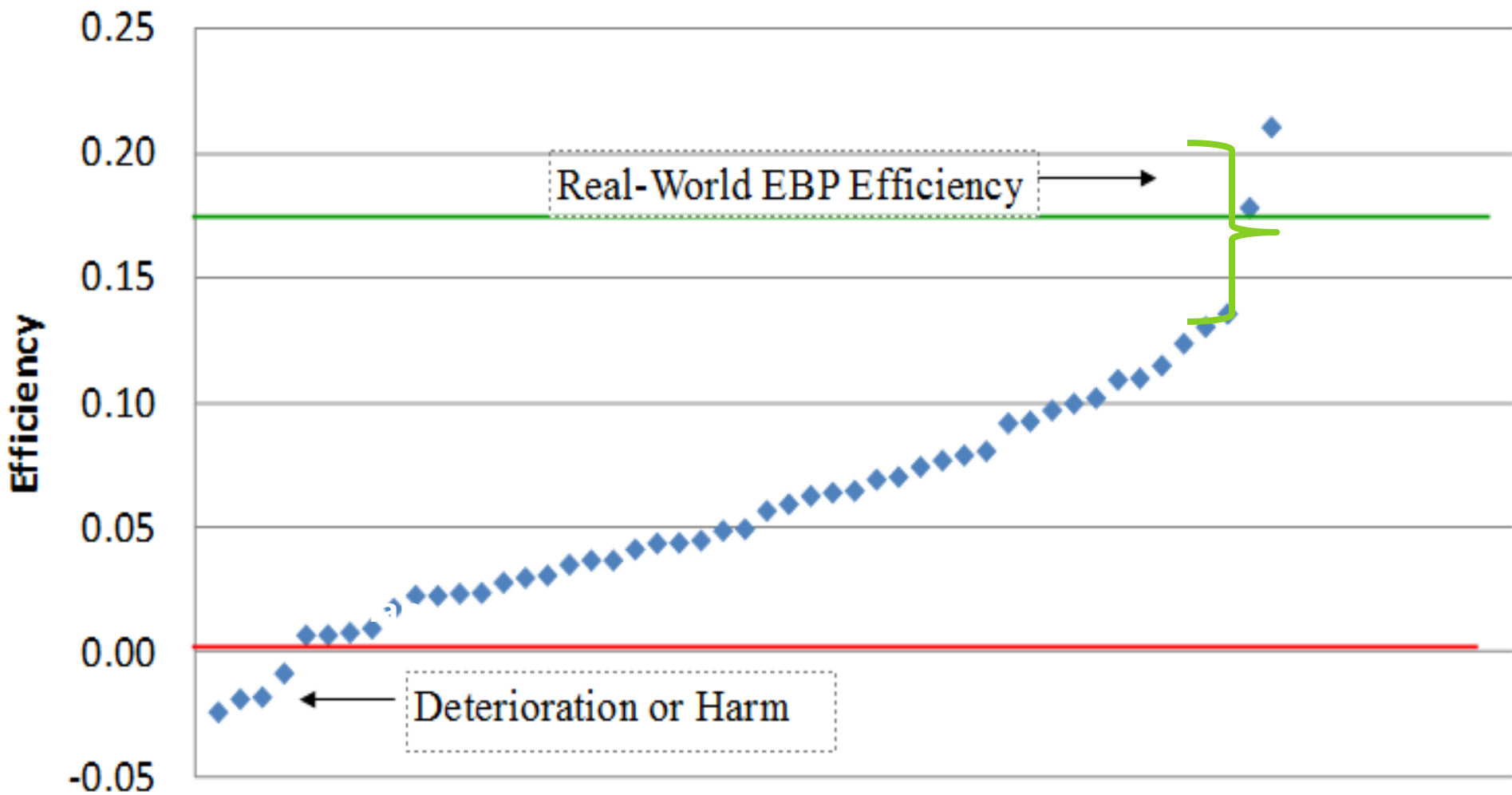
- ▶ Monthly Strategic Planning re: Data Presentation and System Goals
  - ▶ As-Needed Information for Changing System Priorities / Contingencies (specialized reports on school programs, substance using sub-population, and children also involved in child welfare or juvenile justice systems)
  - ▶ Alignment with Multi-Level System Goals (County, State, Federal Government)
- 

# ADMINISTRATORS




# ADMINISTRATORS

## Efficiency by Program



# REPLICATION STRATEGIES

# REPLICATION STRATEGIES

- ▶ Multi-Level and Multi-System Alignment
  - ▶ Data Explicitly for Decision-Making
  - ▶ Attention to the 'Human' Process
  - ▶ Iterative Change
  - ▶ Systems Change Guides and Peers
- 

# **DISCUSSION**

***ROBERT FRIEDMAN, PHD***